STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155203	A. BUILDING B. WING		01/18/2013		
		1		ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF I	PROVIDER OR SUPPLIE	R	203 SPARKS AVE				
HILLCRE	EST VILLAGE			RSONVILLE, IN 47130			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE COM ELTION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0000	This visit was in State Licensur This visit was in Investigation of IN00122444. Complaint IN0 Unsubstantiate sufficient evided Survey Dates: and 18, 2013 Facility Number Provider Number AIM Number: Survey Team: Gloria J. Reise	for a Recertification and the Survey. In conjunction with the of Complaint 0122444 - Led due to lack of tence. January 14, 15, 16, 17, er: 000110 Der: 155203 100271120 ert, MSW/TC 1/15, 1/16, 1/17, and N ype:	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies Please accept this plan of correction as our credible allegation of compliance. Plefind enclosed the plan of correction for survey ending 30, 2012. Due to the low scound severity of the survey find please find sufficient documentation providing evidence of compliance with plan of correction. The documentation serves to conthe facility's allecgation of compliance. Thus, the facility respectfully requests the gran of paper compliance.	e he n on . ase July pe ding, the		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000110

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		A. BUILDING B. WING	00	COMPLETED 01/18/2013			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE					
HILLCRE	ST VILLAGE		RSONVILLE, IN 47130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	Total: 81						
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.						
	Quality review completed on 1/28/2013, by Cheryl Fielden, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I5PZ11

Facility ID: 000110

If continuation sheet Page 2 of 21

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155203	B. WIN			01/18/	2013
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARKS AVE		
UII I CDE	ST VILLAGE				RSONVILLE, IN 47130		
HILLOKE	ST VILLAGE			JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0242	483.15(b)						
SS=D	SELF-DETERMIN	NATION - RIGHT TO					
	MAKE CHOICES						
		the right to choose					
		les, and health care					
	consistent with hi						
		d plans of care; interact					
		the community both inside					
		acility; and make choices his or her life in the facility					
	that are significar						
	triat are significar	it to the resident.	F02	12	What corrective action(s) will b		02/17/2013
	Dagad an maga		1.02	42	accomplished for those reside		02/17/2013
		rd review, observation			found to have been affected by		
	and interview t	he facility failed to			the deficient practice: Reside	•	
	ensure a reside	ent had the right to			#30 was re-interviewed and	,iit	
	choose when to	o get up in the			preferences were revised on C	CNA	
	morning. This	affected 1 of 3			assignment sheet. Resident #		
	•	wed for choices.			getting up later in the		
	(Resident #30)				morning.How will you identify		
	(INESIDEIIL #30)				other resident(s) having the		
					potential to be affected by the		
	Findings includ	e:			same deficient practice and wh		
					corrective action will be taken:		
	Review of the r	ecord of Resident #30			All residents have the potentia	I to	
	on 1/16/13 at 1	0:45 a.m., indicated			be affected by the alleged		
		uded, but were not			deficient practice. The nursir staff will be re-educated by the	•	
	•	jestive heart failure,			Social Services/designee on o		
	_	ssure, dementia, renal			before 02/17/13 on Resident	•	
					Rights with emphasis on hono	rina	
		nemia, gastric reflux,			resident choices An audit w		
	_	, history of stroke,			be conducted to ensure reside		
	history of heart	attack, osteoarthritis,			choices are honored. If change		
	major depressi	ve disorder,			in Resident preferences are		
		, and chronic kidney			identified, the CNA assignmen		
	disease.	•			will be revised. The director of	of	
	2.0000.				nursing services/designee is		
	During on inter	viou on 1/16/12 of			responsible to ensure complia		
	_	view on 1/16/13 at			What measures will be put into		
		Resident #30 she			place or what systemic change) S	
	indicated she	lid not get a choice as			you will make to ensure the		

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Event ID: I5PZ11

Facility ID: 000110

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLI	ETED
		155203	A. BUI. B. WIN	LDING		01/18/2013	
			B. WIIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
LULLODE	OT \				ARKS AVE		
HILLCRE	ST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to when she go	ot up in the morning.			deficient practice does not rec	ur:	
	-	up when they want me			· The nursing staff will be		
	, , ,	they got me up at 4:00			re-educated by the DNS/desig	nee	
	a.m."	they got me up ut 4.00			on or before 02/17/13	.	
	a.111.				on Resident Rights with emph	asıs	
		1/10/10 1 10 11			on honoring resident	_{ff}	
		n 1/18/13 at 10:44 a.m.,			preferences. The activity sta will conduct the Preferences for		
	· ·	ndicated Resident #30			Daily Customary Routines forn		
	"does not like (getting up early and			during the residents quarterly,		
	never has ever	n when she was			annual and significant change		
	downstairs". S	She also indicated that			assessments. These preference		
	Resident #30 s	sometimes refuses to			are reviewed during the IDT		
		norning. She indicated			meetings. The Director of		
		refers to get up around			Nursing/designee is responsib		
	10:00 a.m.	cicis to get up around			to ensure compliance.How the	:	
	10.00 a.m.				corrective action(s) will be	.	
					monitored to ensure the deficie		
		n 1/18/13 at 10:48 a.m.,			practice will not recur: · The C audit tool for Resident Intervie		
	with LPN #1 in	dicated Resident #30			will be utilized weekly x 4 weel		
	had never state	ed a preference for			monthly x 6 months. Finding		
	getting up in th	e morning. If she did it			from the CQI process will be		
		e CNA Sheet. Review			reviewed monthly and an action	n	
		eet indicated there was			plan will be implemented for		
		as far as time to get up			threshold below 95%.		
	•	- -					
		. "They should go in					
		she is ready to get up					
		er rest until she is					
	ready. They a	lways have a choice."					
	On 1/17/13 at	7:30 a.m., Resident					
		ved to be sitting in her					
		tching TV. She					
		vas still tired and					
	wished she wa	is in bea.					
		Resident Rights" was					
	received from	the Director of Nursing					

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155203	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/18/2013			
	PROVIDER OR SUPPLIER EST VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION			
	on 1/18/13 at 3:17 p.m. This policy indicated, "This document informs each resident/responsible party of his/her rights and responsibilities regarding medical care while a resident at the facilityAll staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care" A copy of a "Preferences for Daily Customary Routines" for Resident #30 and dated 10/25/12 was received from the Administrator on 1/18/13 at 5:15 p.m. This document indicated, "Do you have a preference as to what time you get up? "Yes" was marked and then crossed out and there was a check in the no box. 3.1-3(u)(1)						

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Event ID: I5PZ11

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI III	DDIC	00	COMPL	ETED
		155203	A. BUII			01/18/2013	
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIIILODE	CT \		203 SPARKS AVE				
HILLORE	ST VILLAGE			JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG F0323	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D	The facility must on environment remains	ENT ERVISION/DEVICES ensure that the resident ains as free of accident esible; and each resident					
	· ·	e supervision and					
		es to prevent accidents.					
	2.00.012.100 40 1100		F03	23	F323 What corrective action(s)	02/17/2013
	Based on obse	ervation, interview, and			will be accomplished for those		Q2/17/2015
		the facility failed to			resident found to have been		
		ts residing on 1 of 3			affected by the deficient practi		
		rails openings no			Resident #35 and # 70 side		
		75 inches. This			covers were immediately appli to the siderails. How will you	ed	
	_				identify other resident(s) havin	a	
		residents residing in			the potential to be affected by		
	•	were reviewed for side			same deficient practice and wh		
	rails with larger				corrective action will be taken:		
	openings. (Re	sidents #35 and 70)			All residents have the potentia be affected by the alleged	l to	
	Findings includ	le:			deficient practice. · The nursir staff will be re-educated by the	-	
	Durina the initi:	al tour on 1/14/13 at			DNS/designee on or before		
	_	esidents #70 and #35			02/17/13 on ensuring side rail covers are applied to resident		
	•	to have 2 half rails in			side rails An audit was		
		that had openings			conducted of all side rails and	all	
		larger than 4.75			residents with side rails with		
	inches.	larger than 4.70			openiongs greater than 4.75		
	11101163.				inches had side rail covers in	~	
	Op 1/15/12 at a	1:00 n m			place. • The director of nursing services/designee is responsible.	_	
	On 1/15/13 at 4	-			to ensure compliance What		
		were completed on			measures will be put into place	e or	
		or Residents #70 and			what systemic changes you wi	II	
		rails had 4 openings in			make to ensure the deficient		
		he first opening			practice does not recur: The		
		2" by 7", the two middle			nursing staff will be re-educate by the DNS/designee on or	u	
		sured 7" by 7 1/2", and			before 02/17/13 on side rail		
	the fourth open	ning measured 5 1/2"			covers · The Charge nurse is	3	
	•				Strong. The charge harden	-	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
		155203	B. WIN			01/18/2	2013
			B. WIN		ADDRESS CITY STATE ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE				
LIII L CDE	ST VILLAGE						
HILLOKE	ST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	by 7 1/2". Res	sident #70's bed had 2			responsible to check placemer	nt]	
		e head of the bed in the			of side rail covers and docume	nt	
		h these openings.			findings on the daily round		
		bed had one side rail			checklist. Non-compliance wi	ll	
					result in further education		
	in the up positi				including disciplinary action. · The Director of Nursing/design		
		side rail that faced the			is responsible to ensure	ee e	
		t #35's second side rail			compliance. How the corrective	e	
		position, but had a			action(s) will be monitored to	-	
	cover over the	rail to enclose the			ensure the deficient practice w	ill	
	openings.				not recur: · The CQI audit tool	for	
					side rails will be utilized weekly		
	During an inter	view on 1/15/13 at			4 weeks, monthly x 6 months.		
	_	Director of Nurses			Findings from the CQI process		
	•	ed the problem would			will be reviewed monthly and a		
	, ,	-			action plan will be implemented for threshold below 95%.	a	
	be lixed before	she left today.			lor threshold below 95%.		
		ocedure for "Side Rail					
	Assessment Pi	rocedure", dated					
	11/2010, was բ	provided by the DON					
	on 1/18/13 at 2	2:54 p.m. The policy					
	indicated, but v	was not limited to,					
		use is needed by the					
	` '	ble repositioning self in					
		nsferring in and out of					
	ped assisted o	r independently"					
	3.1-45(a)(1)						

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Event ID: I5PZ11

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STATEMEN	NT OF DEFICIENCIES	FICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED	
		155203	A. BUII			01/18/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
LIIILODE	CTVIIIACE		203 SPARKS AVE				
HILLORE	EST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0332 SS=E	483.25(m)(1) FREE OF MEDICO OF 5% OR MOR The facility must a medication error greater. Based on record and interview to ensure they we medication error 5% in that the rows 9.09%. The residents observed in the pack medication pass Resident #30, and Findings include During the medication pass Resident #30, and Findings include During the medication pass Resident #30, and Findings include During the medication on with LPN #2, Resident #2, Resident #30, and have a Fentyl Fall a.m. LPN #2 of available to plate a physician and the taken care of risphysician had of the patch and I new order had pharmacy. She hold the patch pharmacy. It have	cation error rate of rates of five percent or rate of greater than medication error rate his affected 3 out of 10 rved during 4 sees. (Resident #5, and Resident #57). de: dication pass 1/17/13 at 7:45 a.m., resident #5 was due to Patch placed at 8:00 did not have a patch ace on Resident #5. she would notify the the pharmacy to get it ight away. The changed the dose of LPN #2 indicated the not been sent to e received an order to until it arrived from the lad not arrived by 12:00	F03		F332What corrective action(s will be accomplished for thos residents found to have been affected by the deficient practice?Resident #5, Resident #57, and Resident #30 are recieving medications per physician orders and nursi standards of practice. How ot residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?. All residents have the potential to affected by this practice Licensed nurses will be in-serviced on or before 02/17, by the SDC/designee on administering medications to include timeliness and availability Skills check offs where the SDC/designee on medication administration on the solution of the solution of the solution of the solution administration on the solution administration on the solution administration on the solution administration are available. The DNS/designer will be responsible for compliance. What measures we be put into place or what	ng cher all e be /13 will ses or	DATE 02/17/2013
	have a Fentyl Fa.m. LPN #2 dayailable to pla She indicated sphysician and taken care of riphysician had the patch and I new order had pharmacy. She hold the patch	Patch placed at 8:00 did not have a patch ace on Resident #5. she would notify the the pharmacy to get it ight away. The changed the dose of LPN #2 indicated the not been sent to e received an order to until it arrived from the ad not arrived by 12:00			administering medications to include timeliness and availability Skills check offs to be completed for licensed nursiper the SDC/designee on medication administration on obefore 02/17/13 The DNS/designee will conduct a100% audit of medications to ensure all medications are available The DNS/designee will be responsible for compliance. What measures we	ses or e vill	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155203	B. WIN			01/18/2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
LIII L CDE	CT VIII LACE				ARKS AVE		
HILLORE	ST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	During the med	dication pass			practice does not recur? .		
	_	1/17/13 at 8:00 a.m.,			Licensed nurses will be		
		lesident #57 did not			in-serviced on or before 02/17/	/13	
					by the SDC/designee on		
		laily medications			administering medications to		
		did not receive her			include timliness and availabili	ty	
	_	for Parkinson's			Skills check offs will be	an	
	disease which	was ordered for 2			completed for licensed nurses all shifts per the SDC/designed	• • • • • • • • • • • • • • • • • • •	
	times a day. H	ler Folic Acid 1 mg for			on medication administration of		
	anemia which	she was ordered for			or before 02/17/13 Medication		
	evervday. Her	Miralax 17 GMs for			cart/medication room audits wi		
		nich she was to have 2			be conducted weekly to ensure		
	•				medications are available,		
		/. LPN #2 notified the			properly stored and expiration		
		pharmacy. She			dates are within appropriate da	ate	
	received an ord	der to hold the			ranges by DNS and/or designe	e	
	medications ur	itil they came from the			Non compliance with these		
	pharmacy. The	e medications had not			practices will result in further		
	been ordered f	rom pharmacy until			education includingdisciplinary		
		der. They had not			action. The DNS is responsible	e	
		acility by 12:00 p.m.,			for compliance. How the		
	on 1/17/13.	acinty by 12.00 p.m.,			corrective action(s) will be		
	011 1/17/13.				maintained to ensure the		
					deficient practice will not rec	ur,	
	•	dication pass on			i.e., what quality assurance program will be put into		
	1/17/13 at 8:15	a.m., with LPN #3,			· · ·		
	Resident #30 r	equested Tylenol for			-	,	
	pain. There wa	as none available in the					
	•	t for this resident or in				- I	
		_			l -		
					-		
	пош рпашасу	'-			I -		
					the 95% threshold.		
	she indicated a	all nurses are					
	responsible for	pulling the stickers					
	•	. •					
	_						
	Resident #30 r pain. There was medication car the emergency medication had from pharmacy 1/17/13 at 10:1 she indicated a responsible for and reordering	equested Tylenol for as none available in the t for this resident or in drug kit. The d not been ordered 7. 2 a.m., with LPN #1, all nurses are			place?. The CQI audit tool for pharmacy services will be completed weekly x4,monthly 6 months. Findings from th CQI process will be reviewed monthly and an action plan who implemented as needed for any deficient practices below the 95% threshold.	y x e l vill	

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Facility ID: 000110

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203		LDING	NSTRUCTION 00	(X3) DATE COMPI 01/18	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Ε	(X5) COMPLETION DATE
	getting them to not available the to get the medications we next dose or as ordered. The purpose that they want they	chysician is notified ons are not available he nurses an order for them to do." "Re-Order ras received from the sing on 1/18/13 at licy indicated, ensure the resident(s) oply of ordered all times. Procedure: Reorder medications he current supply will ."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155203	B. WING		01/18/2013		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R		ARKS AVE			
	ST VILLAGE			RSONVILLE, IN 47130			
TIILLONE	31 VILLAGE		JEFFER	NSONVILLE, IN 47 130			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0425 SS=E	483.60(a),(b) PHARMACEUTION PROCEDURES, The facility must emergency drugs residents, or obtate agreement descripart. The facility personnel to administration of a language of a languag	CAL SVC - ACCURATE RPH provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed minister drugs if State law under the general licensed nurse. Ovide pharmaceutical may procedures that assure uiring, receiving, administering of all drugs to meet the needs of each employ or obtain the ensed pharmacist who ation on all aspects of the emacy services in the facility. Ord review, observation the facility failed to ations were re-orded in er to ensure continuity on of medications in s did not have vailable at the times e administered. This of 10 residents mg 4 medication pass (Resident #5, Resident dent #57)	F0425	F425 What corrective action(will be accomplished for those residents found to have been affected by the deficient practice? Resident #5, Resident #57, and Resident #30are receiving medications per physician orders and nurse standards of practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Licensed	(s) 02/17/2013 seen ing e pe e to to		
	i manga mala			nurses will be in-serviced on o			

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Event ID: I5PZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/18/2013			
		100203	B. WING		01/18/2013		
	ROVIDER OR SUPPLIER ST VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DE COMPLETION DATE		
	During the medobservation on with LPN #2, R have a Fentyl Fa.m. LPN #2 davailable to plate She indicated is physician and taken care of riphysician had determined the patch and I new order had pharmacy. It has pure the patch and I new order had pharmacy. It have 3 of her davailable. She Stalevo 75 mg disease which times a day. Have 3 of her davailable. She Stalevo 75 mg disease which times a day. Have 3 of her davailable have 3 of her davailable have 3 of her davailable. She Stalevo 75 mg disease which times a day. Have 3 of her davailable have a day harmacy were an order to hold they came from medications have from pharmacy were an order to hold they came from medications have from pharmacy order. They have a fixed part of the patch of	dication pass 1/17/13 at 7:45 a.m., desident #5 was due to Patch placed at 8:00 did not have a patch duce on Resident #5. She would notify the dishe pharmacy to get it ght away. The changed the dose of LPN #2 indicated the not been sent to the ad not arrived by 12:00 3.		before 02/17/13 by the SDC/designee on administ medications, timliness of o medications and medication availability. Scheck offs will be complete licensed nurses per the SDC/designee on medication administration on or before 02/17/13. A 100% audit of medications will be conducted ensure all medications are available. The DNS/designee on the put into place or what systemic changes will be to ensure that the deficient practice does not recur? Licensed nurses will be in-serviced on or before 02 by the SDC/designee on administering medications include timeliness and ava. Skills check offs will be completed for licensed nursel shifts per the SDC/designer on medication administration or before 02/17/13. The is responsible for compliant Non compliance with these practices will result in furthed ucation including disciplicaction. How the correctivaction(s) will be maintained ensure the deficient practivation place? The CQI audicompleted weekly x4, more of the properties will the place? The CQI audicompleted weekly x4, more designed and the place? The CQI audicompleted weekly x4, more designed and the place? The CQI audicompleted weekly x4, more designed and the place? The CQI audicompleted weekly x4, more designed and the place? The CQI audicompleted weekly x4, more designed and the place? The CQI audicompleted weekly x4, more designed and the place of the place weekly x4, more designed and the place weekly x4, more designed and the place of the place weekly x4, more designed and the place of the	sering redering Skills and for some soft steed to space ses will made nt serious on on space son on on space s		
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	A. BUILDING COMPLETED		
		155203	B. WIN			01/18/2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	₹			ARKS AVE	
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130	
		TATEL (ENT. OF DEFICIENCIES	-		,	avs)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
1710		· · · · · · · · · · · · · · · · · · ·		1710	x 6 months Skills check offs	
	_	dication pass on			will be completed for licensed	
		5 a.m., with LPN #3,			nurses on all shifts per the	
		requested Tylenol for			SDC/designee on medication	
	•	as none available in the			administration on or before	
		t for this resident or in			02/09/13 Findings from the	
	the emergency	•			CQI process will be reviewed	
		pharmacy were			monthly and an action plan was be implemented as needed for	
	notified. The m	nedication had not been			any deficient practices below	
	ordered from tl	he pharmacy.			the 95% threshold.	·
	1/17/13 at 10:1	I2 a.m., with LPN #1,				
	she indicated a	all nurses are				
	responsible for	pulling the stickers				
	and reordering	the medications.				
	"Meds are not	available some but not				
	a lot. Sometim	nes pharmacy is late				
		us. If the medicine is				
	not available th	nere is a 4 hour window				
	to get the med	ication so morning				
	_	ould be held until the				
	next dose or a	s the physician				
		physician is notified				
		ons are not available				
		the nurses an order for				
	what they wan					
	A policy titled,	"Re-Order				
		vas received from the				
		rsing on 1/18/13 at				
	12:43. This po	•				
	•	ensure the resident(s)				
	has/have a sup	* *				
		all times. Procedure:				
		l: Reorder medications				
	4 days before	the current supply will				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMP	COMPLETED	
		155203	B. WING			/2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP	CODE	
HILLCRE	ST VILLAGE			ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO	SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	be exhausted					
	A policy to sho medications we "everyday" or "					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPL	ETED
		155203	B. WING			01/18/	2013
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
LIII LODE	OT \				ARKS AVE		
HILLCRE	ST VILLAGE			JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	1	ID	DROVIDED'S DI AN GE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	16	DATE
F0431	483.60(b), (d), (e))					
SS=E		S, LABEL/STORE DRUGS					
	& BIOLOGICALS						
	The facility must	employ or obtain the					
		nsed pharmacist who					
	establishes a sys	tem of records of receipt					
	and disposition of	f all controlled drugs in					
	sufficient detail to	enable an accurate					
		d determines that drug					
		ler and that an account of					
	· ·	gs is maintained and					
	periodically recon	iciled.					
		icals used in the facility					
		n accordance with currently					
	· ·	ional principles, and					
		priate accessory and					
		ctions, and the expiration					
	date when applica	able.					
	In accordance wit	th State and Federal laws,					
		tore all drugs and					
		ked compartments under					
	•	re controls, and permit only					
		nnel to have access to the					
	keys.	mer to have decede to the					
	Noye.						
	The facility must i	provide separately locked,					
		ed compartments for					
		lled drugs listed in					
	_	Comprehensive Drug					
		and Control Act of 1976					
		subject to abuse, except					
		uses single unit package					
	drug distribution systems in which the						
	quantity stored is	minimal and a missing					
	dose can be read	lily detected.					
			F043	31	F431 What corrective action(s)	02/17/2013
	Based on reco	rd review, observation			will be accomplished for thos		
		he facility failed to			residents found to have beer		
		ications in the facility			affected by the deficient		
	ensure an meu	ications in the facility			practice?. Resident # 1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED	
		155203	B. WING 01/18/2013			
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	1			ARKS AVE	
HILLCREST VILLAGE					RSONVILLE, IN 47130	
HILLOKE	31 VILLAGE			JEFFER	RSONVILLE, IN 47 130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	were properly I	abeled with resident's			medication was reordered an	ıd
	name and instr	ructions as to how and			expired medications were	
	when medication	ons were to be given			appropriately removed. How	
		were no expired			other residents having the	
		the medication rooms			potential to be affected by the	
					same deficient practice will b	
		This affected one			identified and what corrective	9
		ad the potential to			action(s) will be taken?. All	
	affect all 81 res	sidents residing in the			residents have the potential t	to
	facility. (Reside	ent #1)			be affected by the alleged	
					deficient practice A 100%	
	Findings includ	le:			audit of all medications will be	
	T manigo morado.				completed to ensure all label are legible. During the audit a	
	On 1/18/13 at /	11:45 a.m., medication			review expiration dates will b	II
		•			conducted to ensure no	
		necked with the Director			expired medications are	
		e medication cart on			present. The audit will be	
		nad a clear plastic bag			conducted by the DNS. Wha	t l
		Bromide 0.5% with no			measures will be put into pla	
	identification as	s to resident they were			or what systemic changes yo	
	for or the instru	ictions for			will make to ensure the	
	administration.	There were 50 vials in			deficient practice does not	
	this had. There	was one bottle of			recur The nursing staff will	
		lent #1 which was			be re-educated by the	
					SDC/designee on or before	
	expired on 11/	14.			02/17/13 on pharmacy policy	on
					proper storage and labeling of	of
		12:20 p.m., in the TCU			medications Medication	
		was Betamethasone			cart/medication room audits wi	
	cream in the ca	art without a name or			be conducted weekly to ensure	e
	instructions. Th	nere was Santyl cream			medications are available, properly stored and expiration	
		ned with no name or			dates are within appropriate da	ate
		it. Two bottles of			ranges by DNS and/or designe	I
		were expired 6/12 and			Non-compliance will result in	I
		on them or instructions			further education including	
					disciplinary action. • The	
		on. Siltussin 4 oz			Director of Nursing/designee	is
		name or instructions.			responsible to ensure	
	Vitamin B-12 w	vith the last name of a				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPLETED
		155203	B. WING			01/18/2013
NAME OF D	PROVIDER OR SUPPLIER		S	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER		2	203 SPA	ARKS AVE	
HILLCRE	ST VILLAGE		J	JEFFER	RSONVILLE, IN 47130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES]	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	ΓAG	DEFICIENCY)	DATE
	resident writter	n on it (there are 2			compliance. How the correcti	
	residents with	that last name) and no			action(s) will be monitored to	
	instructions.				ensure the deficient practice will not recur: • The CQI audi	
					tool for Pharmacy Services w	
	On 1/18/13 at	12:00 p.m., an			be utilized weekly x 4 weeks,	
	interview with t	he Director of Nursing			monthly x 6 months by the Di	
	indicated the n	urses are responsible			and/or designee. · Findings	
	for checking al	l items to be sure they			from the CQI process will be	
	_	d dated correctly. They			reviewed monthly and an	
		checking for expiration			action plan will be	
	dates.				implemented for threshold below 95%.	
					Delow 93 /6.	
	A policy titled,	"Labeling of				
		as received for the				
		rsing on 1/18/13 at 3:17				
	p.m. This police	_				
		All Medications with a				
		ler: Labeling for all				
	l ·	ust be: Typed or				
	printed and cle	- ·				
		Resident/patient				
	full name	ι τοσιαστισματιστιτ				
		Prescription				
	number	i resoription				
	Hallibel	Name and				
	strength of the					
		Route and time				
	(c) the medical	tion is to be given				
	(a) the ineutical	•				
	the preserinties	(if indicated on				
	the prescription	•				
	alm a. //ar = -1! = - 1'	Quantity of				
	drug/medicatio	•				
		Date dispensed				
	-11.45	Expiration date of				
	all time dated of	arugs				

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	of Correction identification number: 155203	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPL 01/18/	ETED		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE		
	Prescriber's name The name, address, and telephone number of the dispensing pharmacy. Any other pertinent information as may be needed or required" 3.1-25(j)(k)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		A. BUILD	A. BUILDING 00			X3) DATE SURVEY COMPLETED 01/18/2013	
		100200	B. WING			01/10/	2013
	PROVIDER OR SUPPLIER			203 SPA	DDRESS, CITY, STATE, ZIP CODE ARKS AVE SONVILLE, IN 47130		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PR	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	(X5) COMPLETION
		ESC IDENTIFY TING INFORMATION)		IAG	,		DATE
F0441 SS=D	483.65 INFECTION CON SPREAD, LINEN The facility must a Infection Control provide a safe, sa environment and development and and infection. (a) Infection Cont The facility must a Control Program (1) Investigates, o infections in the fa (2) Decides what isolation, should b resident; and (3) Maintains a re corrective actions (b) Preventing Sp (1) When the Infe determines that a prevent the spread must isolate the r (2) The facility must a communicable lesions from direct their food, if direct disease.	establish and maintain an Program designed to anitary and comfortable to help prevent the transmission of disease rol Program establish an Infection under which it -controls, and prevents acility; procedures, such as be applied to an individual ecord of incidents and a related to infections. Interest of Infection to the doi: 100 to 10		ΓAG	DEFICIENCY)		DATE
	their hands after	ust require staff to wash each direct resident contact ashing is indicated by ional practice.					
		nandle, store, process and o as to prevent the spread					
	Based on reco	rd review, interview	F0441		F441What corrective action(s will be accomplished for tho		02/17/2013

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPLETED	
		155203	A. BUIL B. WING			01/18/	2013
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARKS AVE		
LII I CDE	ST VILLAGE				RSONVILLE, IN 47130		
HILLORE	31 VILLAGE			JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and observation	on the facility failed to			residents found to have been	1	
	ensure proper	glove use for in that			affected by the deficient		
	gloves were us	sed for multiple things			practice?Resident #122	ro	
	and then for IV	administration. This			is recieving the appropriate ca based on the infection control	ire	
	affected 1 of 1	residents reviewed for			policies and practices. How o	ther	
		on. (Resident #122)			residents having the potentia		
		(100.00.11.11.12)			to be affected by the same		
	Findings includ	1 e.			deficient practice will be		
					identified and what correctiv	е	
	0: 4/47/40 -1	44.45 a LDN #2			action(s) will be taken?. All		
		11:45 a.m., LPN #3			residents have the potential	to	
		dent #122's room to			be affected by the alleged		
	_	e IV fluids. The bag			deficient practice Nursing		
	hanging was a	lmost empty and she			Staff will be re-educated on hand		
	had a new one	to hang. LPN #3 hung		washing, use of gloves policy and			
	the bag of fluid	I on the IV pole and		procedures by the SDC/designee on or before 02/17/13 with post			
	•	inds. She put gloves			test included Skills checks w		
		lled the head of the			be completed for nursing staff		
		ositioned and covered		the SDC/designee on or before		-	
	•	With the same gloves			02/17/13. What measures wil		
					be put into place or what		
		over and changed out			systemic changes will be ma	de	
	the IV bags.				to ensure that the deficient		
					practice does not recur? . T		
		rith LPN #3 on 1/17/13			nursing staff will be re-educate	ed	
	at 11:55 a.m.,	she indicated she			on hand washing, use		
	should have ch	nanged her gloves after			of gloves policy and infection control policy and procedures	by	
	working with th	ne resident before			the SDC/designee on or befor		
	working with th				02/17/13 with post test include		
					Skills checks will be complete		
	A policy titled,	"IV Medication			for nursing staff by the		
		" was received from the			SDC/designee on handwashir	ng	
		rsing on 1/18/13 at			and glove usage on/or before		
		_			02/17/13 SDC and/or design	iee	
	•	is policy indicated,			will observe handwashing	_	
		nds and put on gloves.			technique and monitor infection		
	7. Connect all	equipment"			control practices as it relates t handwashing and glove use 5		
					l manawasining and glove dae o	^	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		A. BUILDING B. WING	00	COMPLETED 01/18/2013	
	PROVIDER OR SUPPLIE EST VILLAGE	R	203 SP	ADDRESS, CITY, STATE, ZIP CODE PARKS AVE RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	3.1-18(a)			per week and include all threshifts and weekends The DNS/designee will be reponst to ensure compliance Non-compliance with these practices will result in further education including disciplina action. How the corrective action(s) will be monitored to ensure the deficient practice not recur: The CQI audit to Infection Control will be utiliz weekly x 4 weeks, monthly x months by the DNS and/ or Designee. Findings from the CQI process will be reviewed monthly and an action plan wimplemented for threshold be 95%.	will ol for ed 6 ne d vill be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I5PZ11

Facility ID: 000110

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